FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040741

Facility Name: DEERBROOK CARE CENTRE

Address: 306 NORTH LARKINN AVE. (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 744-5560 **Fax #** (815) 744-6914

IDPA ID Number: 36-3943427001

Date of Initial License for Current Owners: 04/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	217	Skilled (SNF)	217	79,422	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	217	TOTALS	217	79,422	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,120	1,142	5,929	13,191	8
9	SNF/PED					9
10	ICF	43,746	8,188	1,775	53,709	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,866	9,330	7,704	66,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 84.23%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 3236

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	210,018	28,770	13,070	251,858		251,858	(111)	251,747			1
2	Food Purchase		228,801		228,801	(18,250)	210,551	(3,858)	206,693			2
3	Housekeeping	192,273	49,622	0	241,895		241,895	(493)	241,402			3
4	Laundry	90,300	45,008	2,216	137,524		137,524	1,808	139,332			4
5	Heat and Other Utilities			156,105	156,105		156,105	0	156,105			5
6	Maintenance	53,920	47,308	51,594	152,822		152,822	104	152,926			6
7	Other (specify):*			18,894	18,894		18,894	0	18,894			7
8	TOTAL General Services	546,511	399,509	241,879	1,187,899	(18,250)	1,169,649	(2,550)	1,167,099			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	2,080,456	116,209	12,825	2,209,490		2,209,490	(7,519)	2,201,971			10
10a	Therapy	3,323		0	3,323		3,323	0	3,323			10a
11	Activities	134,224	17,092	438	151,754		151,754	(1,241)	150,513			11
12	Social Services	54,369		663	55,032		55,032	0	55,032			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			520	520		520	0	520			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	2,272,372	133,301	20,446	2,426,119		2,426,119	(8,760)	2,417,359			16
	C. General Administration											
17	Administrative	318,449		663,425	981,874		981,874	(649,738)	332,136			17
18	Directors Fees			0				0				18
19	Professional Services			278,863	278,863		278,863	11,934	290,797			19
20	Dues, Fees, Subscriptions & Promotions			169,016	169,016		169,016	(144,408)	24,608			20
21	Clerical & General Office Expense	197,802	42,841	52,584	293,227		293,227	117,728	410,955			21
22	Employee Benefits & Payroll Taxes			498,645	498,645	18,250	516,895	0	516,895			22
23	Inservice Training & Education			10,884	10,884		10,884	0	10,884			23
24	Travel and Seminar			1,769	1,769		1,769	12,506	14,275			24
25	Other Admin. Staff Transportation			5,641	5,641		5,641	0	5,641			25
26	Insurance-Prop.Liab.Malpractice			16,014	16,014		16,014	129,280	145,294			26
27	Other (specify):*			191,387	191,387		191,387	(191,387)				27
28	TOTAL General Administration	516,251	42,841	1,888,228	2,447,320	18,250	2,465,570	(714,085)	1,751,485			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,335,134	575,651	2,150,553	6,061,338		6,061,338	(725,395)	5,335,943			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			74,022	74,022		74,022	181,945	255,967			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			74,162	74,162		74,162	316,290	390,452			32
33	Real Estate Taxes			79,514	79,514		79,514	0	79,514			33
34	Rent-Facility & Grounds			891,956	891,956		891,956	(875,658)	16,298			34
35	Rent-Equipment & Vehicles			57,156	57,156		57,156	8,258	65,414			35
36	Other (specify):* STORAGE			1,362	1,362		1,362	0	1,362			36
37	TOTAL Ownership			1,178,172	1,178,172		1,178,172	(369,165)	809,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		216,854	153,078	369,932		369,932	0	369,932			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			119,134	119,134		119,134	0	119,134			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		216,854	272,212	489,066		489,066		489,066			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,335,134	792,505	3,600,937	7,728,576	0	7,728,576	(1,094,560)	6,634,016			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(32,158)	30		9
10	Interest and Other Investment Income	(32,989)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,858)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(4,760)	21		18
19	Entertainment	0	20		19
20	Contributions	(3,428)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,367)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(191,387)	27		24
25	Fund Raising, Advertising and Promotional	(134,330)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(8,501)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(452)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (414,230)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(653,761)	G 6 & 6A	34
35	Other- Attach Schedule	(26,569)	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (680,330)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name DEERBROOK CARE CENTRE

IDH 0040741

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			**Line 1**	(111)
1	**Day Care**	0	0	**Line 2**	(3,858)
2	**Other Care for Outpatients**	0	0	**Line 3**	(493)
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	1,888
4	**Non-Patient Meals**	0	2	**Line 5**	556
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	186
6	**Rented Facility Space**	0	34	**Line 7**	93
7	**Sale of Supplies to Non-Patients**	0	10	**Line 8**	(2,500)
8	**Laundry for Non-Patients**	0	4	**Line 9**	0
9	**Non-Straightline Depreciation**	(32,158)	30	**Line 10**	(17,566)
10	**Interest and Other Investment Income**	(32,989)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 11**	(1,284)
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(3,858)	2	**Line 13**	0
14	**Non-Care Related Interest**	0	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 16**	(18,895)
17	**Non-Care Related Fees**	0	20	**Line 17**	(5,504)
18	**Fines and Penalties**	(4,760)	21	**Line 18**	0
19	**Entertainment**	0	20	**Line 19**	(2,500)
20	**Contributions**	(3,428)	20	**Line 20**	(146,220)
21	**Owner or Key-Man Insurance**	0	22	**Line 21**	(8,760)
22	**Special Legal Fees & Legal Retainers**	(2,367)	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 23**	0
24	**Bad Debt**	(191,387)	27	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(134,330)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 27**	(191,387)
28	**Yellow Page Advertising**	(8,501)	20	**Line 28**	(354,295)
29	**Non-Paid Workers**	0	0	**Line 29**	(373,442)
30	**Donated Goods**	0	0	**Line 30**	(52,140)
31	**Amortization Expense**	0	0	**Line 31**	0
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(111)	1	**Line 32**	(32,989)
33	PAGE 5 - LINE 35 VACATION ACCRUAL	(493)	3	**Line 33**	0
34	PAGE 5 - LINE 35 VACATION ACCRUAL	1,888	4	**Line 34**	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	556	6	**Line 35**	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	(17,564)	10	**Line 36**	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	(1,241)	11	**Line 37**	(65,147)
38	PAGE 5 - LINE 35 VACATION ACCRUAL	(5,524)	17	**Line 38**	0
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(4,000)	21	**Line 39**	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	(452)	6	**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(440,399)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(111)	0	0	0	0	0	0	0	0	0	0	(111)	1
2	Food Purchase	(3,858)	0	0	0	0	0	0	0	0	0	0	(3,858)	2
3	Housekeeping	(493)	0	0	0	0	0	0	0	0	0	0	(493)	3
4	Laundry	1,808	0	0	0	0	0	0	0	0	0	0	1,808	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	104	0	0	0	0	0	0	0	0	0	0	104	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,550)	0	0	0	0	0	0	0	0	0	0	(2,550)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(17,564)	10,045	0	0	0	0	0	0	0	0	0	(7,519)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,241)	0	0	0	0	0	0	0	0	0	0	(1,241)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(18,805)	10,045	0	0	0	0	0	0	0	0	0	(8,760)	16
	C. General Administration													
17	Administrative	(5,524)	(644,214)	0	0	0	0	0	0	0	0	0	(649,738)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,367)	5,011	9,290	0	0	0	0	0	0	0	0	11,934	19
20	Fees, Subscriptions & Promotions	(146,259)	1,851	0	0	0	0	0	0	0	0	0	(144,408)	20
21	Clerical & General Office Expenses	(8,760)	126,488	0	0	0	0	0	0	0	0	0	117,728	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,506	0	0	0	0	0	0	0	0	0	12,506	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,960	123,320	0	0	0	0	0	0	0	0	129,280	26
27	Other (specify):*	(191,387)	0	0	0	0	0	0	0	0	0	0	(191,387)	27
28	**TOTAL General Administration**	(354,297)	(492,398)	132,610	0	0	0	0	0	0	0	0	(714,085)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(375,652)	(482,353)	132,610	0	0	0	0	0	0	0	0	(725,395)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,158)	10,581	203,522	0	0	0	0	0	0	0	0	181,945	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,989)	0	349,279	0	0	0	0	0	0	0	0	316,290	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	16,298	(891,956)	0	0	0	0	0	0	0	0	(875,658)	34
35	Rent-Equipment & Vehicles	0	8,258	0	0	0	0	0	0	0	0	0	8,258	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(65,147)	35,137	(339,155)	0	0	0	0	0	0	0	0	(369,165)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(440,799)	(447,216)	(206,545)	0	0	0	0	0	0	0	0	(1,094,560)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe DEERBROOK CARE CENTRI # 0040741 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru

Show Pgs 6E thru 6I

Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, I		MANAGEMENT
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				DEERBROOK NURSING CENTRE		
					ROSEMONT, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	10	NURSING	$	FHC ENTERPRISES INC		$ 10,045	$ 10,045	1	10045
V	17	ADMINISTRATIVE	663,425	" " SEE BELLOWS OWNS 19% OF THIS FACILITY		19,211	(644,214)	2	-644214
V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		5,011	5,011	3	5011
V	20	DUES & SUBSCRIPTIONS		" "		1,851	1,851	4	1851
V	21	CLERICAL		" "		126,488	126,488	5	126488
V	24	TRAVEL		" "		12,506	12,506	6	12506
V	26	INSURANCE		" "		5,960	5,960	7	5960
V	28	DEPRECIATION		" "		10,581	10,581	8	10581
V	34	RENT		" "		16,298	16,298	9	16298
V	35	RENT/EQUIPMENT & VEH		" "		8,258	8,258	10	8258
V								11	
V								12	
V								13	
Total			$ 663,425			$ 216,209	$ (447,216)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 891,956	DEERBROOK NURSING CENTRE		$	$ (891,956)	15	-891956
16	V	19	ACCOUNTING FEES		" "		9,050	9,050	16	9050
17	V	19	LEGAL FEES		" "		240	240	17	240
18	V	26	GENERAL INSURANCE		" "		99,906	99,906	18	99906
19	V	26	MORTGAGE INSURANCE		" "		23,414	23,414	19	23414
20	V	30	DEPRECIATION - BLDG & IMP		" "		189,599	189,599	20	189599
21	V	30	DEPRECIATION - EQUIP & FURN		" "		13,923	13,923	21	13923
22	V	32	AMORTIZATION - MTG COST		" "		3,136	3,136	22	3136
23	V	32	MORTGAGE INTEREST		" "		346,143	346,143	23	346143
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 891,956			$ 685,411	$ * (206,545)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

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STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	19%	SEE ATTACHED	3.1	9.03	SALARY	19,211	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,211		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 72,138	66,900	$ 10,045	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	137,966	66,900	19,211	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987		66,900	5,011	3
4	20	DUES AND SUBSCRIPTION	PATIENT DAYS	480,456	10	13,291		66,900	1,851	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	614,536	66,900	103,343	5
6	21	CLERICAL	HOURS	1	1	23,145	23,145	1	23,145	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,811		66,900	12,506	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		66,900	5,960	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		66,900	10,581	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		66,900	16,298	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		66,900	8,258	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,661	$ 847,785		$ 216,209	25

Print Preview

Print Page 8A

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - DEERBROOK NURSING HOME						$	$			$	1
2	GMAC		X	MORTGAGE	$31,776.00	09/97	4,775,900	4,672,506	09/32	7.375	346,143	2
3	GMAC		X	LOAN COST	AMORT-35 YRS		109,773	99,320			3,136	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	VARIES	VARIES	416,200	2,525,000	VARIES	PRIME +	68,130	6
7	CRESTWOOD HEIGHTS	X		WORKING CAPITAL	VARIES	VARIES	50,000	50,000	DEMAND	0.085	4,420	7
8	FIRST HEALTHCARE	X		WORKING CAPITAL	VARIES	VARIES	27,063	8,289	VARIES	PRIME +	1,612	8
9	TOTAL Facility Related				$31,776.00		$ 5,378,936	$ 7,355,115			$ 423,441	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,378,936	$ 7,355,115			$ 423,441	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	73,176	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	75,926	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,750	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,764	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	79,514	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	71,120	8
	1996	67,164	9
	1997	72,146	10
	1998	72,376	11
	1999	75,926	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	105000	1975	$ 247,500	1
2	754 BASIS ADJ.		1992	13,220	2
3	TOTALS			$ 260,720	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	217			1975	$ 1,849,704	$ 29,750	35	$ 52,849	$ 23,099	$ 1,333,360	4
5				1980	168,687	1,331	20	1,331		168,687	5
6	754 ADJ			1992	125,584	3,987	31.5	3,987		33,891	6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RELATED PARTY - DEERBROOK NURSING CENTRE										9
10	IMPROVEMENTS			1984	33,823	1,691	20	1,691		27,901	10
11	IMPROVEMENTS			1986	21,535	1,120	20	1,077	(43)	15,616	11
12	IMPROVEMENTS			1987	78,860	2,504	20	3,943	1,439	53,676	12
13	IMPROVEMENTS			1988	48,614	1,544	31.5	1,544		18,956	13
14	IMPROVEMENTS			1989	60,430	1,919	31.5	1,919		22,849	14
15	IMPROVEMENTS			1990	30,485	967	31.5	967		9,809	15
16	IMPROVEMENTS			1991	53,134	1,688	31.5	1,688		15,904	16
17	IMPROVEMENTS			1992	117,363	3,725	31.5	3,725		31,039	17
18	IMPROVEMENTS			1993	29,335	932	39	932		7,307	18
19	IMPROVEMENTS			1993	29,864	767	27.5	767		5,625	19
20	IMPROVEMENTS			1994	37,711	1,371	27.5	1,371		8,666	20
21	VINYL SLIDER UNITS			1995	3,070	112	27.5	112		611	21
22	DOORS			1995	2,564	93	27.5	93		508	22
23	ROOF			1996	24,069	875	27.5	875		3,974	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		10,933	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	448,432	16,305	27.5	16,305		54,128	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,833	27.5	57,833		192,220	26
27	OUR TOWN			1998	21,500	782	27.5	782		2,313	27
28	ALZHEIMERS WING CONSTRUCTION-FINAL DRAW			1998	17,009	618	27.5	618		1,829	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		3,228	29
30	DOOR ALARM SYSTEMS			1998	24,760	900	27.5	900		2,663	30
31	SPRINKLERS			1998	3,500	127	27.5	127		376	31
32	DINING ROOM-WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		1,558	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		955	33
34					ADJ. TO SL	24,495			(24,495)		34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 160,116		$ 160,116	$	$ 2,028,582	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	REMODELING OF ELEVATOR - LOBBY			1998	7,050	256	27.5	256		694	9
10	LANDSCAPING			1998	2,815	102	27.5	102		277	10
11	ROOF TO PTAC UNITS			1998	3,508	128	27.5	128		346	11
12	DINING & RESIDENT ROOM FLOORS			1998	15,268	555	27.5	555		1,457	12
13	HOT WATER TANK			1998	1,780	65	27.5	65		170	13
14	REMODELING - SHOWER ROOM			1998	3,830	139	27.5	139		330	14
15	ASPHALT PARKING LOT & SPEED BUMPS			1998	17,156	624	27.5	624		1,378	15
16	WALLCOVERING/WINDOW TRMTS/TILES			1998	18,635	678	27.5	678		1,497	16
17	REMODELING - RESIDENT ROOMS			1998	37,050	1,347	27.5	1,347		2,749	17
18	WINDOW TREATMENTS/REMODEL RMS			1999	18,066	657	27.5	657		1,287	18
19	FIRE ALARM & HVAC/CEILING/HALLS/CALL LIGHTS			1999	25,000	909	27.5	909		1,705	19
20	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS			1999	23,425	852	27.5	852		1,526	20
21	REMODEL ROOMS/DOOR MONITOR SYS			1999	45,989	1,672	27.5	1,672		2,857	21
22	REMODEL RMS/LANDSCAPING			1999	53,572	1,948	27.5	1,948		3,166	22
23	WALLCOVERING			1999	6,950	253	27.5	253		390	23
24	REMODELING RMS			1999	16,205	589	27.5	589		859	24
25	WALLCOVERING/FLOOR TILES/HANDRAILS			1999	28,464	1,035	27.5	1,035		1,423	25
26	REMODELING RMS			1999	47,115	1,713	27.5	1,713		2,213	26
27	NURSE STATION/ELEVATOR DOORS			1999	18,030	656	27.5	656		793	27
28	REMODELING ROOMS/WINDOW TRMTS			1999	170,712	6,207	27.5	6,207		6,466	28
29	FIRE DAMPERS			2000	4,950	173	27.5	173		173	29
30	REMODELING-WASHROOMS/MEDICAL REC. RM			2000	35,550	1,023	27.5	1,023		1,023	30
31	FENCES			2000	3,557	92	27.5	92		92	31
32	WALLCOVERING/WINDOW TRMTS-RES & DINING RMS			2000	69,939	1,378	27.5	1,378		1,378	32
33	FIREWALL,RESIDENT ROOM CEILINGS/TUCKPOINTING			2000	85,160	1,678	27.5	1,678		1,678	33
34	MAGCETIC DOOR/STEAMER			2000	16,334	322	27.5	322		322	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 25,051		$ 25,051	$	$ 36,249	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	HANDRAILS			2000	8,101	135	27.5	135		135	9
10	REMODELING - NURSE STATION/CORRIDOR/DINING RM			2000	126,731	2,113	27.5	2,113		2,113	10
11	PTAC UNITS			2000	3,550	59	27.5	59		59	11
12	CONCRETE PAVING			2000	11,700	195	27.5	195		195	12
13	IRRIGATION SYSTEM & ROOM PLATES			2000	10,425	142	27.5	142		142	13
14	DESIGN & BUILD ENABLING GARDEN			2000	19,832	660	15	660		660	14
15	CARPETING/WINDOW TREATMENT			2000	14,549	154	27.5	154		154	15
16	PTAC UNITS			2000	3,550	38	27.5	38		38	16
17	REMODELING-BREAK ROOM, MEDICATION RM			2000	39,886	423	27.5	423		423	17
18	SIDEWALK			2000	2,240	17	27.5	17		17	18
19	REMODELING-RES. RMS, LOBBY,MAIL ROOM			2000	60,826	461	27.5	461		461	19
20	PTAC UNITS			2000	4,644	35	27.5	35		35	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 4,432		$ 4,432	$	$ 4,432	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
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16											16
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
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16											16
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18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 379,229	$ 62,284	$ 37,879	$ (24,405)	3-10YRS	$ 120,399	37
38	Current Year Purchases	79,706	11,738	3,985	(7,753)	3-10YRS	3,985	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	864,467	24,504	24,504			825,452	40
41	TOTALS	$ 1,323,402	$ 98,526	$ 66,368	$ (32,158)		$ 949,836	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 288,125	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 255,967	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (32,158)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,019,099	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipm $ 36,634 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN.	1998 LEXUS	$ 749.00	$ 10,510	17
18	FACILITY USE	99 DODGE DURANGO	625.00	10,012	18
19					19
20					20
21	TOTAL		$ ######	$ 20,522	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 69,947	$		$ 69,947	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,313			12,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			70,818			70,818	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				116,917		116,917	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY, RENTALS Other (specify):	39-2					99,937		99,937	13
14	TOTAL			$		$ 153,078	$ 216,854		$ 369,932	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 977,503	$ 1,141,922	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,010)	1,652,268	1,652,268	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,503	150,536	6
7	Other Prepaid Expenses	17,334	17,334	7
8	Accounts Receivable (owners or related parties)	1,549,038	1,769,780	8
9	Other(specify): ESCROW DEPOSITS		37,498	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,227,646	$ 4,769,338	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,849,704	14
15	Leasehold Improvements, at Historical Cost		4,056,164	15
16	Equipment, at Historical Cost	458,936	1,251,356	16
17	Accumulated Depreciation (book methods)	(247,741)	(3,191,629)	17
18	Deferred Charges	2,671	206,904	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		351,980	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 213,866	$ 4,771,979	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,441,512	$ 9,541,317	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 325,638	$ 428,709	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	177,792	177,792	28
29	Short-Term Notes Payable	2,587,709	2,587,709	29
30	Accrued Salaries Payable	164,074	164,074	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,467	20,467	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,764	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA	75,019	75,019	36
37	MANAGEMENT FEES	6,332	6,332	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,357,031	$ 3,536,866	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,375	26,375	39
40	Mortgage Payable		4,672,506	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PARTNERS LOANS		174,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 26,375	$ 4,872,881	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,383,406	$ 8,409,747	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,058,106	$ 1,131,570	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,441,512	$ 9,541,317	48

***(See instructions.)**

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 337,939	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 337,939	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	720,167	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 720,167	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,058,106	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,419,085	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,419,085	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,989	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 32,989	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	DISCOUNTS		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 8,452,074	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,187,899	31
32	Health Care	2,426,119	32
33	General Administration	2,447,320	33
	B. Capital Expense		
34	Ownership	1,178,172	34
	C. Ancillary Expense		
35	Special Cost Centers	369,932	35
36	Provider Participation Fee	119,134	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	3,331	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,731,907	40
41	**Income before Income Taxes (line 30 minus line 40)****	720,167	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 720,167	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,882	2,108	$ 78,849	$ 37.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,122	35,660	773,433	21.69	3
4	Licensed Practical Nurses	22,242	24,027	384,612	16.01	4
5	Nurse Aides & Orderlies	77,017	82,152	820,976	9.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	248	255	3,323	13.03	8
9	Activity Director	2,530	2,792	33,778	12.10	9
10	Activity Assistants	11,681	12,551	100,446	8.00	10
11	Social Service Workers	3,789	4,157	54,369	13.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,672	8,337	114,166	13.69	14
15	Cook Helpers/Assistants	13,767	15,028	95,852	6.38	15
16	Dishwashers					16
17	Maintenance Workers	3,656	4,072	53,920	13.24	17
18	Housekeepers	25,014	26,663	192,273	7.21	18
19	Laundry	11,247	12,266	90,300	7.36	19
20	Administrator	3,826	4,136	189,048	45.71	20
21	Assistant Administrator	3,810	4,389	129,401	29.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,682	13,203	197,802	14.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,040	2,183	22,586	10.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,225	253,979	$ 3,335,134 *	$ 13.13	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	208	$ 13,070	1-3	35
36	Medical Director	42	6,000	9-3	36
37	Medical Records Consultant	4	179	10-3	37
38	Nurse Consultant	237	8,141	10-3	38
39	Pharmacist Consultant	240	1,800	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	9	438	11-3	44
45	Social Service Consultant	13	663	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48	UTILIZATION REVIEW	16	2,100	10-3	48
49	TOTAL (lines 35 - 48)	769	$ 32,391		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LEVINSON	ADMIN		$ 157,269
HUSSAIN SIDDIQUE	ASST. ADMIN		55,619
LUCILLE WONAGAS	ASST. ADMIN.		73,782
JEREMY AMSTER	ADM. - TRAINING		31,779
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 318,449

B. Administrative - Other

Description	Amount
FIRST HEALTHCARE - MANAGEMENT FEES	$ 663,425
TOTAL (agree to Schedule V, line 17, col. 3)	$ 663,425
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		278,863
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 278,863

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,387
Unemployment Compensation Insurance	42,883
FICA Taxes	246,744
Employee Health Insurance	135,785
Employee Meals	18,250
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	10,494
EMPLOYEE BENEFITS-OTHER	13,336
EMPLOYEE PHYSICAL EXAMS	16
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 516,895

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,231
Health Care Worker Background Chec	940
(Indicate # of checks perform 78)	
ADV & PROMO/MARKETING	142,831
DUES & SUBSCRIPTIONS	11,789
LICENSES & PERMITS	597
TRUST FEES, CONTRIBUTIONS,etc.	3,428
MGMT CO ALLOCATION	1,851
LESS TRUST FEES, CONTRIB, etc.	(3,428)
Less: Public Relations Expense	( )
Non-allowable advertising	#######
Yellow page advertising	(8,501)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,608

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,769
RELATED PARTY	12,506
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,275

**See instructions.

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Facility Name & ID Num DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	06/97	$ 4,238	3	$ 706	$ 1,413	$ 1,413	$ 706	$	$	$	$	$
2	PAINT/DECORATI	06/98	4,364	3		727	1,455	1,455	727				
3	PAINT/DECORATI	06/2000	3,136	3				523	1,045	1,045	523		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,738		$ 706	$ 2,140	$ 2,868	$ 2,684	$ 1,772	$ 1,045	$ 523	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost rep YES
If YES, give association name and amo IL COUNCIL LONG TERM CARE $6989

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases YES
What was the average life used for new equipment added during this per 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. 3,978 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. 119,134
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? NO If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati 5%
d. Have vehicle usage logs been maintair NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repc YES
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	13070	
	REPAIRS & MAINTENANCE		0	
			0	13070
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		2216	
			0	2216
5	HEAT & OTHER UTILITIES			
	GAS HEAT		20559	
	ELECTRICITY		88793	
	WATER		46725	
	CABLE TV - LOBBY		28	
			0	156105
6	MAINTENANCE			
	GROUNDS MAINTENANCE		9935	
	PAINTING & DECORATING		3136	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18270	
	ELEVATOR MAINTENANCE & REPAIR		7560	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4250	
	FIRE SERVICE		4033	
	DEFERRED PAINTING & DECORATING		4410	
			0	
			0	51594
7	OTHER			
	SCAVENGER		18894	
	SECURITY SERVICE		0	18894
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	6000	6000
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		605	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTA	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	179	
	PHARMACY CONSULTANT	XVIII B39	1800	
	UTILIZATION REVIEW FEES	XVIII B48	2100	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	8141	
			0	
			0	12825
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	0	
	OCCUPATIONAL THERAPY CONSUL	XVIII B41	0	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	0
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	438	
			0	438
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	663	
			0	663
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		520	520
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	663425	663425
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	16361	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	262502	
	ACCOUNT COLLECTION FEES		0	278863
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	134330	
	EMPLOYEE WANT ADS	XIX F	9231	
	CONTRIBUTIONS	VI 20 XIX F	626	
	DUES & SUBSCRIPTIONS	XIX F	11789	
	LICENSES & PERMITS	XIX F	797	
	PUBLIC RELATIONS-PATIENT RELA	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	8501	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2802	
	H/CARE WORKER BACKGROUND CI	XIX F	940	169016
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		485	
	EQUIPMENT REPAIR & MAINTENANCE		5486	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES	VI 18	4760	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		338	
	TELEPHONE		41084	
	MESSENGER SERVICE		431	
			0	52584

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	246744	
	UNEMPLOYMENT COMPENSATION	XIX D	42883	
	WORKERS COMPENSATION INSURA	XIX D	49387	
	HOSPITALIZATION INSURANCE	XIX D	135785	
	EMPLOYEE BENEFITS - OTHER	XIX D	13336	
	EMPLOYEE PHYSICAL EXAMS	XIX D	16	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRII	XIX D	10494	
	CHICAGO HEAD TAX	XIX D	0	498645
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		10884	10884
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1769	
			0	
				1769
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		5641	5641
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		16014	16014
27	OTHER			
	BAD DEBTS	VI 24	191387	
			0	191387
	GRAND TOTAL COLUMN 3 OTHER			2150553